Project Report

REVIEW OF FUNDING FOR THE MENTAL HEALTH RESIDENTIAL PROGRAM

Prepared for

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Submitted by

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Background and Structure of Report

In September 1991, Peat Marwick Thorne were contracted to conduct a review of the funding in the Mental Health Residential Program. This followed a meeting between the then Minister of Health and a number of proprietary facility operators who made oral and written submissions on the inadequacy of current funding. This report contains the findings, conclusions, and recommendations of the review.

In spite of the brevity of the review period (just seven weeks), we believe we have been able to touch on the issues which are key to an understanding of both the program and funding requirements in providing care to mental health clients. Our results are based on personal interviews with 37 individuals in a selection of ten residential care facilities and five regional Mental Health offices. Additionally, information from these personal interviews was supplemented by an in-depth written survey of all facility operators, of which we heard back from over sixty.[1]

We begin our presentation of the results with a review of the compensation methods currently used by the Ministry of Health in this area, and a brief commentary of the cost trends we have observed in residential care. We then provide you with a sample of our survey and interview results and our assessment of the Revised Payment System which is presently in use by a handful of proprietary facility operators. Finally, our conclusions and recommendations are summarized at the close of our report.

We would like to take this opportunity to thank all those contributing their time and knowledge during this review. We hope we have captured the essence of their comments in support of strengthening mental health residential care in the province.

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1 *A total of 139 facilities were sent questionnaires—116 profit, and 23 non-profit.*

I

Current Methods of Reimbursement

A. Program background

The Community Residential Program provides, among other things, residential care to the province's mental health clients. Most of this program is delivered through 141 boarding homes to approximately 1,860 clients. 120 of these licensed residential facilities are proprietary, and the remaining 21 are non-profit. Although the program has been in existence for over thirty years, Mental Health Services only assumed full responsibility for these homes in 1984, when responsibility was transferred from the Long-Term Care Program.

At that time, Mental Health Services also continued to use the care levels which had been (and continue to be) in use in Long-Term Care:

- **Personal Care**—The client requires minimal assistance.
- **Intermediate Care 1 (IC1)**—The client demonstrates moderate impairment.
- **Intermediate Care 2 (IC2)**—The client has intermittent but severe psychiatric problems.
- **Intermediate Care 3 (IC3)**—The client suffers from severe, ongoing psychiatric problems.

The operation of these mental health facilities, including staffing and licensing, is governed by the **Community Care Facility Act** and accompanying Adult Care Regulations. General policy and procedures for the facilities are set out in the Community Residential Program Policy and Procedures manual. There are three categories of licence under which a facility is authorized to operate:

- *Specialized Care License*—which authorizes a facility to provide both personal and intermediate care
- *Personal Care License*—which authorizes a facility to provide personal care only

- *Intermediate Care License*—which authorizes a facility to provide intermediate care only. Most of the facilities funded by Mental Health Services under this program are licensed as Specialized Adult Residential Care; a few facilities are licensed to provide only Personal or Intermediate Care.

B. Methods of reimbursement

Proprietary and non-profit facilities are funded in different ways by Mental Health Services. These methods of reimbursement are described below.

1. Proprietary Facilities

Privately managed (proprietary) facilities are reimbursed on a per diem basis by Mental Health Services, with different rates of payment determined by the client's approved level of care.

a) Per diem rates for each resident day

Under this reimbursement model, which applies to a substantial majority of proprietary facilities, per diem rates are based on the rates given by the Long-Term Care Program in 1984/85, when the residential program was transferred. Mental Health Services has revised the rates upward each year, primarily based upon (but less than) an inflation factor, although in two years (1988/89 and 1989/90), at the lower care levels, increases exceeded the rate of inflation. (see Exhibit-I-1)

A stepped rate system is used which reimburses facilities according to the relative levels of care the different classes of client may require (and as determined by Mental Health Services).

Exhibit I-1
Per diem rates—Proprietary facilities 1984-1992

	1984/85 Rates $	%	1985/86 Rates $	%	1986/87 Rates $	%	1987/88 Rates $	%	1988/89 Rates $	%	1989/90 Rates $	%	1990/91 Rates $	%	1991/92 Rates $
Personal Care	20.60	1.7	20.95	1.7	21.30	6.6	22.70	15.6	26.25	13.5	29.80	4.0	31.00	1.0	31.30
IC1	26.50	1.7	26.95	1.7	27.40	5.1	28.80	12.3	32.35	11.0	35.90	4.0	37.35	1.6	37.95
IC2	31.70	1.7	32.25	1.6	32.75	4.6	34.25	11.0	38.00	9.9	41.75	4.0	43.40	1.8	44.20
IC3	49.35	1.7	50.20	1.6	51.00	0.5	51.25	1.5	52.00	1.4	52.75	4.0	54.85	2.3	56.10
Extended Care	49.35	1.7	50.20	1.6	51.00	0.5	51.25	1.5	52.00	1.4	52.75	4.0	54.85	2.3	56.10
CPI Increase[2]		3.2		3.3		3.1		3.6		4.4		5.5		5.5	

The funding increase in 1991/92 ranged from 1.0% for Personal Care to 2.3% for Intermediate Care (Level 3) and Extended Care; in the prior year the increase was 4.0%. Over this eight year period the average annual percentage increase has been:

- Personal Care 6.5%
- Intermediate Care I 5.4%
- Intermediate Care 2 4.9%
- Intermediate Care 3 1.7%
- Extended Care 1.7%

These compare to an average annual percentage increase of 4.1% in the CPI.

Until 1991, the increases provided were comparable to the increases provided to Long-Term Care facilities with fewer than 15 beds; however, last year Long-Term Care rates increased approximately 13% (in 1991/92 the comparable Long-Term rates range from $34.76 for Personal Care to $65.59 for Extended Care).

2 *Based on the Vancouver CPI .*

Each client in a licensed residential facility contributes a portion of the per diem payment through a fixed daily user fee. For the vast majority of clients, where they receive Old Age Security or Guaranteed Income Supplement, the Ministry of Social Services pays the user fee, on behalf of the client, directly to the facility operator. The user fee is increased every quarter and, for single clients, it currently stands at $22.60.

Payments under the per diem method are made twice monthly through Continuing Care's computer payment system. Facility operators are not required to enter into a specific contract for receipt of these payments, but they require appropriate approval and a provider number. Mental Health Services does not require operators to account for how they spend the funding, or to provide financial statements (although there is a requirement contained in the Regulations to the Community Care Facility Act).

b) Negotiated per diem rates

All facilities who are B.C. Pricare members have negotiated a per diem rate, which is based upon the standard per diem, but is slightly higher (6 cents higher). The negotiated increase occurred some years ago and has been carried forward ever since. It was apparently introduced to compensate operators for dues paid to B.C. Pricare. Some other facilities have had their per diem rates frozen for the 1990/91 and 1991/92 years, since they received increases in earlier years to compensate for disparity in wages.

c) Revised payment system

This system was introduced in 1990/91 by Mental Health Services to account for differences between facilities' operating costs and capital investments and to combat the perceived regressive nature of the per diem payment system. Under this system, facility operators present an annual budget and negotiate annual funding payments with a regional representative of Mental Health Services. Funding is intended to cover four kinds of costs: salaries and benefits; food and supplies; property; and administration. The salaries and food components are negotiated based on the prior year's actual costs, supported by detailed financial information. In addition, projected inflation and other specific increases are identified. The property component is based upon a fair market rental value for the region. The administrative component is uniformly set at $3 per bed per day.

Once agreement has been reached between the facility operator and Mental Health Services, a residential services contract is entered into stipulating the total funding for the contract year. The contract makes it possible for Mental Health Services to ensure that standards are being met. The annual contracted funding is divided into monthly payments, based on anticipated operating expenditures, which are processed by Mental Health Services. No distinction is drawn, under this payment method, between different levels of care, nor is

account taken of unoccupied beds. A limited number of facilities have signed an agreement to receive funding under this reimbursement method. These include six facilities where the property is owned and managed by a non-profit society, the Katherine Sanford Housing Society. For these latter facilities, payments are broken down into payments made both to the Service Provider (a contractor who operates the facility) and the Housing Society.

2. Non-profit facilities

Non-profit facilities are funded on the basis of operating budgets which are reviewed with and approved by Mental Health Services. A per diem rate of funding is calculated based upon the budgeted costs of operating the facility, including food and administration, and obtaining certain occupancy levels. In addition, non-profit facilities can apply for funding to assist with planned capital repair and renovation costs. Once approved, these are then calculated into the per diem rates.

The per diem rate of funding is intended to cover all of the per diem operating costs, but with no allowance for any surplus. If a non-profit facility has an operating deficit at year-end, Mental Health Services will reimburse the facility if it can be demonstrated that the deficit resulted from actual occupancy levels falling below budget.

Under this method, non-profit facilities enter into a residential services contract similar to the revised payment systems, which enables Mental Health Services to enforce its service standards. Clients at non-profit facilities are classified into differing care levels in the same way as the clients in proprietary facilities. Payments to non-profit facilities are made monthly through Continuing Care's computer payment system.

II

Trends in Cost Factors

Since the transfer from Long-Term Care, there has been a significant increase in the number of beds available to clients. There were estimated to be approximately 1,400 clients served by these facilities in 1984/85; the figure is close to 1,900 today. However, there is still a need for more beds as well as for more facilities. The trend in recent years has been for a greater number of younger people, who are more disabled, (many with drug and alcohol-related problems) and who represent a less stable population, to enter the facilities. Moreover, the homes which have been opening have been smaller (under 10 beds) and have not been sufficient to meet the increasing demand. It has been estimated that another 300-400 beds will be needed in the next ten years to meet existing demand, and these will be required in smaller facilities.

Coincident with this trend to smaller facilities, there has also been a greater application of standards of care for each facility operator to follow. Such standards have included the direct and indirect staffing case standards and the enforcement of Section 12 of the *Community Care Facility Act* restricting the number of beds to a room.

Many of the facilities are quite old and, although it was expected that a portion of the per diem funding was intended for upgrading facilities to meet the new standards and to be suitably renovated, this has, apparently, frequently not happened.

Finally, staff at an increasing number of Long-Term Care facilities have become unionized in recent years, which has had an (indeterminate) impact upon the salaries paid to staff in proprietary facilities, most of which remain non-union. Most of the non-profit facilities have been unionized for a number of years.

These trends have combined to have a number of effects on a facility's cost of operations:

- The increasing demand (and consequent supply) of available beds has increased the funding requirement.
- The relatively young population has meant a higher turnover among facilities, thus increasing the amount of program administration time and the number of empty beds in facilities between occupancies.

- The effect of an increasing number of unionized staff in other facilities, especially Long-Term Care, has both exacerbated the funding discrepancies between union and non-union facilities, and increased the pressure for non-union facilities to provide comparable wages or suffer a high turnover of staff.

- With the smaller facilities, any vacancy is more noticeable and yet the operating costs would not be proportionately less. According to our written survey (Exhibit III-16d), the occupancy rate in general is lower in smaller facilities, thus compounding the problem.

- The increase in (or rather the establishment of) firm standards has meant that facilities now have to comply with more stringent requirements. This has had the effect of increasing the per capita costs (e.g., wages) without any corresponding change in funding, other than potentially re-assessing the levels of care.

- With the increasing age in facilities, additional funds are necessary for the renovations required to satisfactorily meet care and facility standards.

Each of these factors has had an adverse effect on the operating margins of facility operators and exacerbated the funding pressures on Mental Health Services. Moreover, although not covered in the course of this review, there has been some suggestion that the quality of care provided to clients has suffered as a result since, in fact, standards are not being uniformly met and (some) operators are attempting to continue to keep operating costs to a minimum.

III

Survey Results

A. Introduction

In addition to the documents review and selected interviews, we also mailed out a questionnaire to all proprietary (profit) and non-profit facilities participating in the Mental Health Residential Program. As of November 7, 1991, we had received 62 responses (several others have since been received). This corresponds to a 45% response rate. These 62 have been computerized and analyzed statistically. These results form the basic content of this chapter. Comparisons with population statistics (e.g., on size or type of facility) do not suggest any major deviations.

Before proceeding with the statistical results, it is worth noting the questionnaire sent to the facilities is attached as Appendix D to this report. While our discussion may shorten and paraphrase questions, the full wording can be referenced in this Appendix. It should also be noted that we have fairly small sample sizes (49 profit and 13 non-profit facilities) This will make statistical significance hard to achieve in any comparisons (e.g., between profit and non-profit facilities). However, in many cases the differences are interesting, and will be presented in that light, i.e., as indicative, if not purely statistically significant, results.

B. Results

1. Service definition and client profile

Exhibit III-1 shows the basic description of the facilities responding to the questionnaire. We see that almost all facilities (56 out of 60 responding) have the specialized care license. The majority of facilities (69.4%) were less than 20 beds, and only 3% were 40 beds or more. In Exhibit III-1c, the distribution of resident days is shown. Slightly fewer than 13% of the facilities were under 1,000 resident days. The median was about 5,000 resident days. Over 20% of the facilities indicated 8,000 or more resident days.

Exhibit III-1
Service definition and client profile

a) Facility license (Q 1.1)	Frequency	%
Personal Care	1	1.6
Intermediate Care	2	3.2
Specialized Care	56	93.5
Other	1	1.6

b) Number of beds (Q1.2)	Frequency	%
0-19	43	69.4
19-39	17	27.4
> 39	2	3.2

c) Total occupancy (resident days) (Q1.3)	Frequency	%	Cumulative %
0-1,000	8	12.9	14.0
1,000-2,000	1	1.6	15.8
2,000-3,000	5	8.1	24.6
3,000-4,000	7	11.3	36.8
4,000-5,000	7	11.3	49.1
5,000-6,000	4	6.5	56.1
6,000 -7,000	5	8.1	64.4
7,000-8,000	6	9.7	75.4
8,000-9,000	5	8.1	84.2
9,000-10,000	2	3.2	87.7
> 10,000	7	11.3	100.0
Missing	5	8.1	

Exhibit III-2 below shows some differences between profit and non-profit facilities in terms of size. While almost all of the non-profit facilities were under 20 beds (84.6%), profit facilities had 65.3% in the under 20 beds category, and 32.7% between 21-40 beds (versus 7.7% for the non-profit facilities).

Exhibit III-2
Facility size: profit and non-profit

	0-20 beds	21-40 beds	> 40 beds
Non Profit	11 (84.6%)	1 (7.7%)	1 (7.7%)
Profit	32 (65.3%)	16 (32.7%)	1 (2.0%)

2. Levels of care

Exhibit III-3 shows the distribution of resident days across care levels. To see how to read this exhibit, we read across the first line as follows:

- 51 (out of a total of 62 facilities) indicated 0%, i.e., none, of their resident days were personal care days. This represents 82.3% of the facilities saying no personal care days.
- 25 out of 62 (43.5% of the facilities) said 0% of the resident days were IC1 level days.
- 12.9% of the facilities indicated no IC2 days, and only one facility (1.6%) said there were no IC3 resident days.
- Almost all (91.9%) of the facilities had 0% of the resident days given to extended care.

Some of the key observations coming out of this exhibit are:

- Very few resident days were in personal care.
- About three quarters of the facilities said that IC1 level resident days represented 30% or less of their total resident days.
- IC2 and IC3 level care were clearly the most common levels:
  - about half the facilities said IC2 level care represented over 30% of their resident days.
  - 21% of the facilities indicated IC3 level care represented between 50% and 60% of their total, and only about 5% of the facilities had under 10% of their care at the IC3 level.

Exhibit III-3
Distribution of resident days across levels of care (Q 1.4)

Proportion	Personal Care	IC-1	IC-2	IC-3	Extended Care
0%	51 (82.3%)	25 (43.5%)	8 (12.9%)	1 (1.6%)	57 (91.9%)
1-10%	6 (9.7%)	7 (11.3%)	3 (4.8%)	2 (3.2%)	1 (1.6%)
11-20%	2 (3.2%)	11 (11.7%)	10 (16.1%)	7 (11.3%)	
21-30%	1 (1.9%)	8 (12.9%)	10 (16.1%)	11 (17.7%)	1 (1.6%)
31-40%		5 (8.1%)	12 (19.4%)	16 (25.8%)	
41-50%		1 (1.6%)	10 (16.1%)	10 (16.1%)	
51-60%		1 (1.6%)	7 (11.5%)	13 (21.0%)	
61-70%					
71-80%					
81-90%					
>90%					1 (1.6%)
Missing	2 (3.2%)	2 (3.2%)	2 (3.2%)	2 (3.2%)	2 (3.2%)

Exhibit III-4 shows the differences between profit and non-profit facilities in providing different levels of care. We see that:

- Over 91% of profit facilities had a 0%-1% personal care level resident days, while this was true for only 61.5% of the non-profit facilities.
- The differences in IC1 level care are less, although almost half the profit facilities had 0%-1% of their resident days going to IC1, versus 30.8% for non-profit.
- Almost half (46.2%) the non-profit facilities indicate that IC2 level care constituted over 40% of the resident days. This figure was only 23.4% for profit facilities.
- IC3 level care was much more common in profit facilities, with 42.5% indicating over 60% of the resident days were IC3 (the comparable figure is 23.1% for the non-profit facilities). Less than 10% of the profit facilities showed IC3 level care representing under 20% of the total. For non-profit facilities, it was much greater (46.2%).

Summarizing these observations, we **see that non-profit facilities are significantly higher in IC2 level care, and profit facilities are significantly higher in IC3 level care.**

This may be due to a number of factors, such as:

- The assessment process itself.
- The incentives, e.g., for proprietary facilities, being paid more on a per diem for IC3 patients, encourages the filling of its beds with such patients.

However, we have done nothing further to substantiate this.

Exhibit III-4
Level of care: profit and non-profit

Personal Care	0%-1%	1%-40%
Profit	8 (61.5)	5 (38.5)
Non-Profit	43 (91.3)	4 (6.4)

Intermediate Care-1	0%-1%	1%-20%	> 20%
Non Profit	4 (30.8)	5 (38.5)	4 (30.8)
Profit	23 (48.9)	13 (29.6)	11 (23.4)

Intermediate Care-2	0%-20%	20%-40%	> 40%
Non Profit	4 (30.8)	3 (23.1)	6 (46.2)
Profit	17 (36.2)	19 (40.4)	11 (23.4)

Intermediate Care-3	0%-20%	20%-60%	> 60%
Non Profit	6 (46.2)	4 (30.8)	3 (23.1)
Profit	4 (8.5)	23 (48.9)	20 (42.5)

Exhibit III-5a shows the stability of level of care, with 22.6% of the facilities indicating changing levels of care this year. Exhibit III-5b shows an appropriate total 50-50 split in commenting on the fairness of the level of care assessment process (23 out of 54), but significant differences between profit and non-profit facilities. All non-profit facilities felt the level-of-care assessment process was fair, versus only 34.6% of the profit facilities.

Exhibit III-5
Other level of care characteristics

a) Were proportions in care levels stable in 1991? (Q1.5)

	Frequency	%
Yes	46	74.2
No	14	22.6
Missing	2	3.2

b) Fairness of assessment (Q1.2)

	Fair	Unfair
Non-profit	13 (100%)	0 (0%)
Profit	10 (34.6%)	31 (66.0%)

C. Local and facility factors

The description of the facility buildings themselves are shown in Exhibit III-6, where we see the largest number of buildings (33.9%) are 20-40 years of age, with 24% under 20 years old, and about 26% over 60 years of age. The differences between profit and non-profit are slight on this variable, but facilities over 60 years of age represented 23.4% of the total for the profit class, but 38.5% for the non-profit category.

Exhibit III-6c was an indicator of the conditions of the facility. The responses show over 70% of the facilities require major renovation work.

Exhibit III-6
Facility characteristics

a) Age of building (Q2.1)

Age (years)	Frequency	%
0-20	15	24.2
20-40	21	33.9
40-60	.8	12.9
60-80	13	21.0
> 80	3	4.8
Missing	2	3.7

b) Age of building

	Years									
	0-20		20-40		40-60		60-80		> 80	
Non-profit	3	(23.1%)	4	(30.8%)	1	(7.7%)	5	(38.5%)	0	(0%)
Profit	12	(25.5%)	17	(36.2%)	7	(14.9%)	8	(17.0%)	3	(6.4%)

c) Renovations required (Q2.2a)

Frequency	%
44	71
18	29

1. Location

Exhibit III-7a shows that the majority of facilities (64.5%) are within 3 km of a municipality. However, profit and non-profit facilities are sited differently:

- All non-profit facilities are within 3 km of a municipality.
- Only 57% of the profit facilities are within 3 km of a municipality, and over 8% more than 10 km. from a municipality.

Exhibit III-7
Distance

a) Distance from nearest municipal or service centre	Kilometers	Frequency	%
	0 - 3	40	64.5
	3-10	16	25.8
	10-20	3	4.8
	>20	1	1.6
	Missing	2	3.2

b) Distance from municipality	0 -3 km	3 - 10 km	>10 km
Non-profit	13 (100%)	0 (0%)	0 (0%)
Profit	27 (57.4%)	16 (34.0%)	4 (6/5%)

2. Costs

Exhibit III-8 shows the distribution of various operating and capital costs (on a per bed basis) for the sampled facilities. We see, in this exhibit, that:

- The majority (70.9%) of facilities had property taxes per bed less than $300.
- Similarly, (72.5%) of facilities had annual hydro charges less than $300, and 73.2% had annual heating costs under $300.
- Annual capital costs per bed were distributed fairly evenly over the $0-$5,000 range, with 12.9% of the facilities under $200, 17.7% between $200 and $600, 21% between $600 and $3,000, 11.3% between $3,000 and $5,000, and 6.5% over $5,000. It should be noted that 19 facilities did not respond to this question.
- About half (46.8%) of the sampled facilities had capital costs per bed under $500, and 9.6% were over $2,000 per bed

Exhibit III-8
Costs

a) Annual property taxes (Q 2.6a) per bed (Q 1.2)

Taxes	Frequency	%
0-100	8	12.9
100-200	18	29.0
200-300	18	29.0
300-400	4	6.5
>400	0	6.5
Missing	10	16.1

b) Annual Hydro charges (Q 2.6b) per bed (Q.1.2)

Charges	Frequency	%
0-150	18	29.0
150-200	11	17.7
200-300	16	25.8
300-400	5	8.1
>400	3	4.8
Missing	9	14.5

c) Annual heating costs (Q 2.6c) per bed (Q 1.2)

Taxes	Frequency	%
0-150	22	35.5
150-200	12	19.4
200-300	11	17.7
300-400	3	4.8
>400	4	6.5
Missing	10	16.1

d) Annual capital costs (Q2.6d) per bed (Q1.2)

Charges	Frequency	%
0-200	8	12.9
200-600	11	17.7
600-1000	4	6.5
100-3000	9	14.5
3000-4000	7	11.3
>5000	4	6.5
Missing	19	30.6

e) Annual maintenance costs (Q 2.6d) per bed (Q 1.2)

Costs	Frequency	%
0-200	6	9.7
200-350	9	14.5
350-500	14	22.6
500-1100	14	22.6
1100-2000	3	4.8
>2000	6	9.7
Missing	10	16.1

In Exhibit III-9, non-profit and profit facilities are compared on the various costs per bed measurements discussed above. We see that:

- All non-profit facilities (but no profit facilities) had property taxes per bed under $100.

- Maintenance charges per bed. While 20.9% of the profit facilities had maintenance charges per bed of under $350, the corresponding figure for the proprietary facilities was 66.7%. Similar differences exist at the high end; no non-profit respondents had per bed maintenance costs over $1,100, while 21.0% of the profit facilities had costs in this category.

Exhibit III-9
Cost differences

a)	Annual property taxes per bed	<$100		$100-$300		>$300	
	Non-Profit	8	(100)	0	(0)	0	(0)
	Profit	0	(0)	36	(81.8)	8	(18.2)
b)	Annual hydro charges per bed	<$200		$200-$300		$300	
	Non Profit	7	(77.8)	2	(22.2)	0	(0)
	Profit	22	(50.0)	14	(31.8)	8	(18.2)
c)	Annual capital costs per bed	$0-$600		$600-$3000		>$3000	
	Non-Profit	4	(44.4)	4	(44.4)	1	(11.2)
	Profit	15	(44.1)	9	(26.5)	10	(29.4)
d)	Annual maintenance charges per bed	<$350		$350-$500		$500-$1000		>1100	
	Non-Profit	6	(66.7)	2	(22.2)	1	(11.1)	0	(0)
	Profit	6	(20.9)	12	(27.9)	13	(30.3)	9	(29.4)

This would suggest that, in every category, proprietary facilities are paying more per bed for each of these costs than non-profit facilities. We have done nothing further to substantiate this.

3. Wages

Exhibit III-10 shows the distribution of lowest and highest wages. For the lowest wage, over 60% of the facilities had a minimum wage under $8.00, and only 3.2% had a minimum wage exceeding $10.00. For the maximum wage, we have a median wage of about $15.00, with almost 18% exceeding $18.00.

In Exhibit III-10c, we show what the respondents feel the facility owner should be paid on an annual basis. Almost 41% felt a salary over $40,000 was warranted for owners.

Exhibit III-11 shows the wage difference between profit and non-profit facilities. For the lowest wage paid, no non-profit facility paid under $8.00 per hour, while 83% of the profit facilities fell in this category. For the maximum wage paid, this pattern was somewhat reversed. Only 21.3% of the profit facilities had a maximum wage under $12.00, while the comparable figure for non-profit facilities is 46.2%. At the upper end, the differences become very minor; about 31% of the non-profit group have a maximum wage over $16.00, while 34% of the profit group fall in that category.

Partially explaining some of these numbers are differences in the degree of unionization. In this survey, 9 of 13 non-profit facilities (69%) were unionized, versus only one (of 49 answering) of the profit group.

Exhibit III-10
Wages

a) Lowest hourly wage

Per Hour	Frequency	%
< $6.00	10	16.1
$6. - 8.00	29	46.8
$8. - 10.00	19	30.6
> $10.00	2	3.2
Missing	2	3.2

b) Highest hourly wage

Per Hour	Frequency	%
$10. - 12.00	16	25.8
$12. - 14.00	10	16.1
$14. - 16.00	14	22.6
$16. - 18.00	9	14.5
> $18.00	11	17.7
Missing	2	3.2

c) Reasonable wage for owners

Per Hour	Frequency	%
$0 - 10,000	1	4.5
$10 - 20,000	4	18.2
$20 - 30,000	3	13.6
$30 - 35,000	1	4.5
$35 - 40,000	4	18.2
>$40,000	9	40.9

Exhibit III-11
Wage differences

a) Lowest hourly wage	< $6.00	$6-$8.00	$8-$10.00	> $10.00
Non-Profit	0 (0.0)	0 (0.0)	11 (84.6)	2 (15.4)
Profit	10 (21.3)	29 (61.7)	8 (17.0)	0 (0.0)

b) Highest hourly wage	$10-$12.00	$12-$14.00	$14-$16.00	$16-$18.00	> $18.00
Non-Profit	6 (46.2)	1 (7.7)	2 (15.4)	2 (15.4)	2 (15.4)
Profit	10 (21.3)	9 (19.1)	12 (25.5)	7 (14.9)	9 (19.10)

C. Funding

1. General characteristics

Exhibit III-12 shows basic funding characteristics. Exhibit III-12a shows that only 11 facilities (around 18%) have ever received start-up or capital-improvement funds. About 22% of the facilities responded that they had received other funding. However, there were major differences between profit and non-profit facilities. Only 13% of the profit facilities had received other funding (possibly, for example, private pay clients), versus 53.8% of the non-profit respondents. Exhibit III-12c shows 71% had some funding shortfall over the last 5 years. About a third (32.3%) had at least one funding surplus.

Exhibit III-12
General funding characteristics

a) Start-up or capital improvement funds	Frequency	%
Have received	11	17.7
Never received	49	79.0
Missing	2	3.2

b) Received other funding (Q3.6)	Yes	No
Non Profit	7 (53.8%)	6 (46.2%)
Profit	6 (13.0%)	40 (87.0%)

c) Total funding shortfall (Q3.7)	Frequency	%
Yes	44	71.0
No	15	24.2
Missing	3	4.8

d) Total funding surplus (Q3.8)	Frequency	%
Yes	20	32.3
No	36	58.1
Missing	6	9.7

D. Funding options

1. Basic per diem (BPD)

The responses of those using the Basic Per Diem plan are shown in Exhibit III-13 as seen in this exhibit:

- Only 4.3% feel the plan adequately covers operating costs.
- 6.5% feel it adequately covers capital costs.
- 2.1% feel it adequately covers wage costs.
- Only 13.6% feel the process itself is fair.

Exhibit III-13e addresses the question of what it would take to make the Basic Per Diem Plan adequate (broken down by level of care). Although there was significant non-response to this, particularly for personal care and extended care, we can still see patterns, such as:

- 12 of 15 (80%) of respondents feel personal-care-level per diems should be increased to over $40.00 (it is currently $31.00).
- About half (15 of 29) feel IC1 scales should exceed $60.00 (currently $37.35).
- 60% of respondents felt IC2 scales should be over $60.00 a day (currently $43.40).
- Almost all respondents felt IC3 per diems should exceed $60.00, and almost 30% felt they should exceed $80.00 (they are currently $54.85).
- 80% of the respondents felt extended care payments should be over $60.00 per day (currently $54.85).

Exhibit III-13
Basic per diem

a) Adequately covers operating costs (Q4a.2)

	Frequency	%
Adequate	2	4.3
Inadequate	45	95.7

b) Adequately covers capital costs (Q4a.3)

	Frequency	%
Adequate	3	6.5
Inadequate	43	93.5

c) Adequately covers wage costs (Q4a.4)

	Frequency	%
Adequate	1	2.1
Inadequate	46	97.9

d) Is the BPD process fair?

	Frequency	%
Yes	6	13.6
No	38	86.4

e) Level of funding required under BPD

	S0-S20	S20-S40	S40-S60	S50-S80	>S80
Personal Care	1	2	5	7	0
IC-1	0	1	13	12	3
IC-2	0	1	13	18	3
IC-3	0	1	2	25	10
Extended Care	0	1	1	5	3

2. Budget Calculated Per Diem (BCPD)

The responses of the eight respondents participating in BCPD are shown in Exhibit III-14. The basic results are:

- 37.5% feel it covers operating costs.
- Half responding feel it covers capital costs.
- 37.5% feel it covers wage costs.

Exhibit III-14d, on the fairness of the plan, led to a fairly heavy response from facilities funded by the other plans. In total, 29.4% felt that the process is fair.

Exhibit III-14
Budget calculated per diem (BCPD)

a) Covers operating costs	Frequency	%
Yes	3	37.5
No	5	62.5

b) Covers capital costs	Frequency	%
Yes	3	50
No	3	50

c) Covers wage costs	Frequency	%
Yes	3	37.5
No	5	62.5

d) Is the BPD process fair?	Frequency	%
Yes	10	29.4
No	24	70.6

3. Negotiated Reimbursement Plan (NRP)

Similar to the previous section, we consider the responses to the NRP (seven respondents are under the plan). As shown in Exhibit III-15:

- Over half feel it covers operating costs.
- 2 of 5 respondents said it covered building costs.
- 3 of 7 said it covered wages.

We had 40 respondents to the NRP fairness question. One quarter (25%) of these felt the NRP is fair.

Exhibit III-15
Negotiated reimbursement plan (NRP)

a) Covers operating costs (Q4c.2)	Frequency	%
Yes	4	57.1
No	3	42.9

b) Covers building costs (Q4c.3)	Frequency	%
Yes	2	40.0
No	3	60.0

c) Covers wage costs (Q4c.4)	Frequency	%
Yes	3	42.9
No	4	57.1

d) Is the BPD process fair? (Q4c.5)	Frequency	%
Yes	10	25.0
No	30	75.0

E. Derived statistics

From the questionnaire, we calculated estimates, for each facility, of capital costs, total occupied (or resident) days, unoccupied beds per day, capital costs per resident per occupied day. These are shown in Exhibit III-16 (Appendix E describes their calculation).

Exhibit III-16a show the capital costs per resident per occupied day (which is currently reimbursed at $7.00). This table shows 60% of the respondents had capital costs per resident per occupied day of less than $7.00. Over 34%, though, had costs over $10.00.

However, the capital costs per resident per day are more interesting when looked at as differences between profit and non-profit facilities. As seen in Exhibit III-16b, 42.9% of the non-profit facilities had costs under $4.00 per day (possibly due to CMHC or other subsidies), and none had costs over $7.00 a day. For profit facilities, however, half the facilities had costs over $7.00 a day, and only 17.9% had costs under $4.00 per day.

We also examined the occupancy rates of the various facilities. Our calculations (Exhibit III-16c), based on the number of unoccupied beds per day, show:

- 12.3% operating at over-capacity, and 15.8% right at capacity.
- 12.3% operating with over five beds per day unoccupied.
- The largest number (35.1%) averaging between 0-1 unoccupied beds.

These numbers are somewhat surprising, showing a high overcapacity utilization and a high number of facilities with high vacancy rates.

To analyze these numbers in more detail, we looked at the vacancy rates by facility size and by profit-non-profit differentiation. Exhibit III-16d shows:

- For small facilities (under 20 beds), while a large number (41%) fall in the 0-1 category, there is a sizable percentage (15.4%) averaging five unoccupied beds or more per day.
- For the larger facilities, there are more in the 1-5 category, but only 6.3% in the five or more class

When considering the unoccupied bed rates for profit and non-profit facilities, we see, as the most salient observation, that significantly more facilities are overcapacity in the non-profit group (30.8%) versus 7.7% for the profit category. We also see a similar result for the at-capacity segment (30.8%) of the non-profit facilities versus 12.8% for the profit category). **This greater utilization in the non-profit facilities likely affects some of the funding problems, as proprietary facilities operating on per diems for occupied beds find themselves further and further strapped for funds. This could lead to a number of perverse consequences, e.g., maintaining patients in proprietary homes longer than necessary.**

Exhibit III-16
Derived statistics

a) Capital costs per resident per occupied day *

Costs	Frequency	%
$0-$4.00	8	22.9
$4-$6.00	9	25.7
$6-$7.00	4	11.4
$7-$8.00	1	2.9
$8-$10.00	1	2.9
$10-$14.00	6	17.1
> $14.00	6	17.1

** The current reimbursement is $7.00 per diem.*

b) Costs per day

	0-4	4-6	6-7	> 7
Non-profit	3 (42.9%)	2 (28.6%)	2 (28.6%)	0 (0%)
Profit	5 (17.9%)	7 (25.0%)	2 (7.1%)	14 (50%)

c) Unoccupied beds per day

Beds	Frequency	%
Over capacity	7	12.3
0	9	15.8
0-1	20	35.1
1-2	7	12.3
2-3	4	7.0
3-5	3	5.3
> 5	7	12.3

d) Unoccupied beds by facility size

Unoccupied	0-20	> 20
Over capacity	5 (12.8%)	2 (11.1%)
0	6 (15.4%)	3 (16.7%)
0-1	16 (41.0%)	4 (22.2%)
1-2	3 (7.7%)	4 (22.2%)
2-3	1 (2.6%)	3 (16.7%)
3-5	2 (5.1%)	1 (5.6%)
> 5	6 (15.4%)	1 (5.6%)

e) Level of funding required under BPD

	$0-$20	$20-$40	$40-$60	$50-$80	>$80
Non-profit	4 (30.8)	4 (30.8)	2 (15.4)	0 (0)	3 (23.1)
Profit	3 (7.7)	5 (12.8)	18 (46.2)	11 (28.2)	2 (5.2)

IV

Summary of Findings From Interviews and Written Submissions

A. Introduction

During the course of the review we conducted 37 interviews with Ministry staff and facility operators from four of the five regions, as well as with Ministry program management staff in Victoria. A detailed list of people interviewed is included in Appendix B. In addition, we reviewed written submissions sent by facility operators and non-profit societies to the Minister of Health and to staff in the Ministry of Health. Finally, we reviewed material supplied by B.C. Pricare. A summary of this information is outlined below; Appendix C provides a summary of a wide range of the comments received.

B. Results

The information submitted and views obtained confirm the following:

- The per diem method of funding is considered wholly inadequate by the proprietary facility operators and is leading to a serious financial situation for many of them; this has been exacerbated by increases not keeping pace with inflation and higher standards of care being imposed.

- Incentives provided by distinctions between care levels for per diem funding purposes are unsound since they do not promote improvements in treatment of residents.

- The revised payment system removes the *"artificial"* distinction between levels of care and also removes the need to keep beds full: there is general acceptance of the concept of funding based upon capacity as compared to occupancy.

- This revised system has, however, caused a great deal of extra work for Mental Health Services staff, by requiring more time for analyzing financial information and for negotiating contracts.

- There will continue to be increasing funding pressures on the system caused by increased demands from a more disabled clientele.

- The revised system facilitates monitoring and enforcement of staffing levels.

- Non-profit facilities generally received higher funding than proprietary facilities; primarily these facilities are older and have a higher proportion of administrative staff, and pay higher wages.

- There is an increasing recognition of the significant requirement for capital replacement and upgrading of facilities: the current level of per diem funding does not provide proprietary facilities with any amounts for these.

- The business relationship between Mental Health Services and facility operators works with varying degrees of success: between many program staff and proprietary operators there is mutual mistrust, caused by the view that many operators are primarily in the business for making a profit.

- The Continuing Care funding model has appeared to work well in recent years and for larger (over 15 beds) facilities, services provider agreements are established which commit to both funding and service. For smaller facilities, per diems have recently been increasing above inflation.

These comments generally supported the information received from the survey. They have assisted us in forming our overall findings and conclusions.

V

The Effectiveness of the Revised Payment System

In addition to the written survey and interviews with facility operators and program staff, we discussed the development of the revised payment (reimbursement) model with the architect of the system. The pros and cons of this method from the point of view of both the facility operator and of Mental Health Services personnel are discussed below.

From the operator's point of view, the benefits of the revised reimbursement system are:

- The revised payment system funds operators on the basis of legal capacity and not actual occupancy levels; this removes the uncertainty surrounding the level of funding to be received during the year.

- Similarly, there is no distinction between levels of care, thus operators no longer have to be concerned over the type of client and the concern that although a particular client may require the highest level of individual attention, due regard is not paid to that in classifying the individual for funding purposes.

- For those owner-operators who work full-time in the facility (a large proportion), the revised system would provide adequate compensation for their services in the salaries and wages negotiated. This would guarantee remuneration, as opposed to the per diem method which does not always provide enough for owner-operators' salaries.

However, from the operators' point of view, there is a great deal of concern:

- There is a scepticism that any incremental funds are available and, therefore, that universal application would simply mean a re-distribution of existing funds among the proprietary facilities.

- Inadequate funds are provided to cover transportation costs, salaries and benefits, and no amount is provided for a return on investment.

- The increase in standards, to which operators will be required to agree in a residential services contract, will require additional funding which is not considered to be available.

- The cost components are separated so that no flexibility is allowed the operator; there is a lack of flexibility (and incentive) which prevents the facility operator from becoming more efficient and hence make a return on investment from food supplies and wage costs components.

- The negotiations for the costs to be included in an agreement are perceived to be conducted on a regional basis by Mental Health Service staff; there is uncertainty whether there will be equity between facilities and between regions unless the negotiation is conducted on a broader scale.

From the program point of view, the benefits of the revised reimbursement system are:

- The abandonment **for funding purposes** of the distinction between levels of care means standards are more capable of being enforced because unit cost figures are broken down sufficiently to allow them to monitor those standards which are enforceable under the agreement.

- There is little latitude for operators to play with the staffing ratios—FTEs are also enforceable under the agreement.

However, Mental Health personnel are concerned with the time it takes to negotiate agreements and the lack of increased funding which is likely to be required to meet the needs of this reimbursement system.

There is undoubtedly a great deal of suspicion, by many facility operators, surrounding the application of the revised payment system. In particular, they believe the funding method will provide them with similar, or less, funding than the per diem method, and that it would set a contractual straitjacket which would allow them no opportunity for flexibility in providing care and/or for making a profit.

Our analysis of four proprietary facilities in Vancouver, which have moved to the revised payment system, suggests that, in fact, these facilities are receiving more funding under the revised system than remaining under the per diem system.

This analysis discloses that for each of these facilities there has been a significant increase in funding, ranging from 8.2% to 30.7%. The greater increases occur in the lower levels of care. Intermediate Care 3 represents 48% of the total client mix and would still get increases, but the larger increases would pertain for those facilities providing lower levels of care (Personal Care to Intermediate Care 2). The increment would obviously depend upon the approved agreement costs. If there were universal acceptance of the revised payment system and these increased amounts pertained across the program, the impact on the Mental Health Services budget would be significant.

Exhibit V-1
Comparison of revised payment system to per diem system (1991/92)

Vancouver Facilities		Richmond	Seaport	Waterloo	Southdale
Number of licensed beds		6	8	9	7
Level of Care					
PC	$ 31.00			153	
ICI	$ 37.95	459	153	1,125	306
IC11	$ 44.20	459	246	91	
IC111	$ 56.10		459		612
Number of Bed Days (year-to-date)		918	858	1,369	918
Partial payments made (per diems)		$ 37,707	$ 42,429	$ 51,505	$ 45,946
Average daily rate		$ 41.08	$ 49.45	$ 37.62	$ 50.05
Approved reimbursement under revised payment system		$ 53.68	$ 64.12	$ 47.71	$ 54.12
% increase under revised system		30.7	29.7	26.8	8.2

The revised payment system can be considered a more effective funding model than the existing per diem model because it removes the artificial distinction between levels of care for funding purposes and, instead, funds on the basis of capacity. It would also appear, as is shown above, to provide a greater level of funding to operators. However, in order to succeed there must be:

- Greater acceptance by both program staff and facility operators of this funding model.
- More flexibility in the funding arrangements provided.
- Some consideration given to an adequate return on investment.

If these are brought about then (a variant of) the revised payment system can be considered to be more effective as a funding mechanism.

VI

Findings and Conclusions

A. Findings

- The level of funding is considered, by both Mental Health Services personnel and facility operators, to be the key factor which has impeded the quality of care provided to clients. The program is considered to be ineffective because of the lack of funding when compared to other health programs, and comparisons are frequently made between Mental Health Services and with the Long-Term Care Program. In the past five years, all facilities have experienced funding shortfalls in one or more years. Without question, the level of funding has had a detrimental effect on the program.

- Those facilities operating under the basic per diem method of funding are largely not satisfied that this method of funding covers the cost. (As seen in Exhibit III-13b, only 4.3% of the facilities felt the funding was adequate).

- Funding pressures have resulted in distortions in the levels of care to which clients are assigned, with the effect that confidence in these care classifications has been eroded.

- There are significant differences between the funding of proprietary and non-profit facilities. In 1990/91 (see Appendix A), the average amount paid to non-profit facilities was $48.13 per resident day compared to $28.85 paid to proprietary facilities. These differences cannot be explained by the number of beds in various care levels; indeed, since the preponderance of clients at non-profit facilities are receiving lower levels of care (1CI and IC2), we would expect a much smaller difference.

  Undoubtedly, much of the difference is attributable to different operating costs, with a significant portion of non-profit facility costs incurred in unionized salaries and benefits. Generally, much higher salary and wage levels are found in the non-profit facilities.

- Although we did not audit the quality of care or levels of service between proprietary and non-profit facilities, there appears to be a higher level of service provided in non-profit facilities. Many proprietary facility operators confirm that the funding pressures have inhibited their ability to meet the

standards of care required in the Mental Health Services Policy Manual. Since the level of funding is, however, higher in non-profit facilities it is difficult to determine which type of facility provides better value for money.

- There are variances between funding of mental health residential care facilities and the funding of similar health care facilities in other sectors (in particular, those in Continuing Care). Long-Term Care is a different program: its residents are generally immobile and therefore need all day supervision, while Mental Health Services residents are generally mobile. Moreover, Long-Term Care has many unionized facilities with a significant wage disparity. However, its recent funding increases do not appear equitable when compared to that provided to the Mental Health residential care facilities; each type of funding was apparently to cover inflation, but for Mental Health Services, the amounts were significantly less.

- The age and condition of buildings in which mental health clients are housed will increasingly become a cause for concern. Many non-profit facilities are older, but these receive funding for repairing and renovating the facilities. With the increasing physical standards for proprietary facilities (the enforcement of Section 12 of the Community Care Facility Act) and the lack of funding afforded by facility owners in the part of upgrading the facilities, available resources will be reduced further until facility standards set by the Ministry have been met.[3]

- The increases in basic client per diem rates have hardly kept up with inflation; they have certainly not accommodated higher service and facility standards instituted by the Ministry (although it could be argued that funding in earlier years was sufficient to meet those standards).

- Although required to provide financial information under the Regulations contained in the *Community Care Facility Act*, this information has either not been forthcoming or that provided to the Ministry by facility operators has been insufficient to establish per diem on the basis of *"real"* operating costs.

- The revised payment system is not liked by mental health staff or by proprietary facility operators: Mental Health Services staff are reluctant to push these agreements since the negotiations require extra administrative effort; operators are reluctant to be tied into a contract for a fixed period, and one which restricts their ability to manage the operations independently.

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3 *According to the written survey, 71% of the facilities are in need of a major renovation.*

B. Conclusions

In the course of our review, which included an analysis of a number of facilities as well as interviews and a survey of facility operators, it is clear that the level of funding is currently inadequate. Standards of care are being compromised and many proprietary operators feel they cannot meet the current minimum staffing levels. As a result, the relationship between the Ministry and the proprietary facility operators is not always a very healthy or cooperative relationship.

In addition, there is general mistrust on the part of many program staff towards the proprietary facilities. There is concern that standards of care are not being maintained, that quality of care suffers at the expense of profit, and that the operators do not have the care of the client as their fundamental operating principle.

The long-term care funding model (for facilities greater than 15 beds) has some alternative aspects which can be incorporated into a mental health funding model; for instance, the averaging of facility costs supported by financial reports, to arrive at a per diem. There is, however, a high administrative cost in operating this model. Similarly, the model used in funding the Katherine Sanford Housing Society has a number of features which can be incorporated into a universally applied funding model. These include the distinction drawn between (and separate contractual arrangements for) the owner of the facility and the operator. In particular, with the ability to call for proposals to provide residential services or operate a facility, it is likely that the process of setting a fair market price would become easier.

For proprietary facilities operating under the per diem method of funding, the Ministry of Health does not appear to have a contract which it can enforce in terms of the conduct of the facility operator. Additionally, under the existing per diem reimbursement model, operators of facilities appear to have a financial disincentive to effectively rehabilitate residents, since this will result in their receiving a lower rate of funding.

The per diem reimbursement model has no adequate mechanism for funding empty beds caused by temporary factors. In these times of high turnover of clients, these temporary factors are increasing.

Finally, it is clear that the vast majority of beds will continue to be proprietary facilities—at least in the short to medium term. Therefore, a funding structure which attempts to provide funds to remove deficiencies in care levels should be put in place. Over the longer term, there is merit in increasing the number of facilities which operate in a similar way to the Katherine Sanford model.

VII

Recommendations

A. Develop a more equitable funding structure

First of all, in the short-term, additional funding should be made immediately available to fund proprietary facilities on a par with inflation (a greater increase similar to that provided in the Long-Term Care Program should be provided for 1991/92). As a principle, inflation rate increases should be consistent across programs within the Ministry of Health. The additional $4.9 million required to put Mental Health Services on a par with the per diem funding in Long-Term Care should be provided. However, instead of funding the per diem system, these funds should be used to reimburse individual operators on the basis of real costs incurred. Until financial statements are provided by facility operators, no specific increases in funding should be provided.

Second, the discrepancies between the funding provided non-profit facilities and proprietary facilities should be investigated and, where appropriate, removed. For example, if the major differences in funding are caused by higher salaries (as compared to more staff) then some allowance should be given to proprietary facilities to enable the quality of their staffing complement to be upgraded. This can only be achieved by determining the **real** costs of doing business, and encouraging facilities to prepare a business case to demonstrate comparative salaries outside the facilities.

If a flat-rate method of payment continues, there should be a mechanism which allows contingencies to be paid for or base rates to be increased. A business case method might allow for this.

B. Separate the capital from the operating portion of the funding

The risks associated with ownership of the facility should be appropriately rewarded. Owners of proprietary facilities should, therefore, be given funds which compensate for this. The payment of the equivalent of a fair market rental would appear to provide an adequate level of compensation. Those owners who own the facility outright would be getting a return on their investment; those who have high mortgages would receive a rental to offset the mortgage costs.

The funding of these capital costs should, furthermore, be separated from the funding of operating costs. This leads conceptually, to a distinction between the ownership and the operation of the facility. For instance, if the operator does not meet the standards, he or she could be removed and another operator put in their place. Similarly, to adequately compensate the operators for their risk, it is imperative that they be provided with some form of profit element on top of negotiated operating costs. The Katherine Sanford model provides some framework upon which such a formula could be used.

Separation of the capital and operating costs suggests two possible funding components:

- A per diem component to cover operating costs. Such a per diem could be calculated for all facilities (in a particular category) by determining their operating costs and providing, as is the case with Long-Term Care, an average. If these were found to be significant, justifiable differences in operating costs between facilities, then individual per diems might be considered. This, however, is less profitable.

- A negotiated, budget-driven component for capital costs. Such a component would be derived from the fair market rental equivalent, referred to earlier.

Effectively, this dual component proposal supports the greater application of a modified revised payment system.

C. Do not use the funding mechanism as a means of imposing standards

The most important requirement is clearly to provide an adequate level of client care; this must not be compromised. However, it should be possible to segregate the clinical *"service"* requirements from the operation of the facility. This is necessary since we have seen, in some cases, a refusal to fill vacancies being used as a way to compel facilities to perform to standard (a totally improper way of enforcing performance under a contract). The measures for policing standards can and should be carried out independently from the day-to-day operational requirements of the facility.

D. Remove the distinction between levels of care for funding purposes

There is no useful funding purpose served in continuing the different levels of care. They should therefore be removed for this purpose but probably retained for other (quality of care) purposes.

E. Other recommendations

Finally, our review suggests that consideration should be given to:

- Moving the administration and funding of the Social Services user fee to the Mental Health Program, since it is cumbersome and unwieldy to have the funding sources split in this way.

- Establishing an agreement which sets out appropriate standards of care, and which requires each facility operator to perform to these standards in order to continue to receive funding. It would make sense to employ an individual (or a contractor) as a central contract negotiator to effect these agreements—at least, in the Vancouver/Lower Mainland regions. This insertion of an intermediary for assisting in the negotiation process would help to remove some of the mistrust which exists between program staff and facility operators, and would probably improve the relationship. This relates to recommendation B above.

- Developing standard financial reporting requirements (and formats) with the information reported regularly (semi-annually or quarterly) to the Ministry as an integral part of the funding agreement. In order to support the annual discussion of funding arrangements, financial statements should be required for all facilities. The Ministry should be prepared to fund the cost of preparation of these financial statements which would probably be audited. In addition, there should be a recognition of, and commitment to, the additional financial staff resource requirements this would entail.

- Specifying in any contract or agreement with operators, the performance expectations and standards as the deliverables of the contract, and not engage in component funding as the negotiated payment system does, i.e., staff/resident rates may be implied in the standards, but the dollar should not necessarily be tied to the total staff complement.

With immediate attention paid to the funding requirement, and a critical path developed for timely implementation of the other recommendations, Mental Health Services will have a much more consistent and defensible funding framework than exists today.

Appendix A

Analysis of Payments Made for 1990/91

Appendix A

Analysis of Payments Made for 1990/91

Care Category	Number of Facilities	Number of Resident Days Funded	Average Daily Rate (excluding user fee)	Total Payments for the year ended March 31/91
Service Provider Payment System				
Non-Profit Facilities	19			
Personal Care		3,163	$38.75	$122,592.00
Intermediate Care 1		23,734	$32.66	$775,231.00
Intermediate Care 2		40,118	$36.71	$1,472,846.00
Intermediate Care 3		24,532	$36.42	$893,615.00
Adjustments*				$1,142,761.00
	19	91,547	$48.13	$4,407,045.00
Proprietary Facilities	123			
Personal Care		5,769	$9.18	$53,000.00
Intermediate Care 1		60,259	$15.51	$935,192.00
Intermediate Care 2		156,347	$21.04	$3,290,030.00
Intermediate Care 3		340,551	$33.08	$11,267,022.00
Extended Care		1,254	$34.33	$43,052.00
Adjustments*				$688,606.00
	123	564,180	$28.85	$16,276,902.00
	142	655,727	$31.54	$20,683,947.00
Contract Payments				346,805.00
				$21,030,752.00

* *These adjustments are comprised of retroactive pay on per diem increases, capital expenditures, compensation for revenue shortfalls due to vacant beds, and error corrections. No further breakdown of this figure was possible.*

Appendix B

List of People Interviewed

Appendix B

List of People Interviewed

Mental Health Residential Program

Victoria

MHS
- Paul Charron, Director Adult and Acute Services
- Kelly Moran, Senior Financial Analyst
- Rudi Denys (previously Program Coordinator)

Continuing Care
- Paul Pallan, Executive Director
- Jim Redford, Director

Okanagon/Kootenay Region

MHS
- Regional Director, Ken Greene
- Director, Kelowna, Kim Marshall

Facilities
- Braemore Lodge, Penticton, Npo, 18 Beds
  - Kathy Miller, Administrator
  - Sandy McNaughton, Admin. Assistant
  - Nihal Maligaspe, Chairman Of The Board
- Oak Lodge, Kelowna, Private, 22 Beds
  - Myrna Belanger, Owner/manager
- Villa Vista, Kelowna, Private, 10 Beds
  - Marilyn Brown, Owner/operator

Fraser Valley/North Shore Region

MHS
- Barney Osborne, Regional Coordinator
- Randy James, Acting Director, New Westminster
- Alan Clark, Social Worker, New Westminster
- Ken Lerner, Director, Langley
- Linda Dennys, Social Worker, Langley
- Laura Koby, Social Worker, Surrey

Facilities

Pioneer House, Npo, New Westminster, 29 Beds
Colleen Dewar, Administrator
Good Shepherd Rest Home, Private, Langley, 10
Beds Wayne Mills, Owner/operator
Velray, Private, Surrey, 35 Beds, Felicidad Velo
Owner/operator
Greenwood (old and new), Private, Surrey, 10 Beds each
Bill Massey, Owner/operator

Vancouver Island Region

MHS

Dennis Suwala, Regional Director
Gayle Milbank, Coordinator, Adult Program
Wendell Coady, Director, Victoria
Tom Newton, Social Worker, Victoria
Diane Williamson, Director, Nanaimo
Janet Walters, Social Worker, Nanaimo

Facilities

Brook Manor, Private, Victoria, 32 beds
Larry Jaworski, Owner
Greenridge Place, Private, Victoria, 10 Beds
Mark Salton, Owner
Columbia Centre Society, Npo, Nanaimo, 10 Beds
Bob Currie, Administrator

Greater Vancouver Mental Health Services Society (GVMHSS) Region

MHS

Linda Thomas, Director of Housing
John Russell, Executive Director

Facilities

Westminster House,
Andre Chevrier
Coast Foundation
Darrell Burnham
Stirling House
Cathy Easdowne
Ken Easdowne

Additional Written Submission reviewed

B.C. Association of Private Care
Bill Bramwell, Director of Funding and Analysis

Appendix C

Summary of Findings from Interviews and Written Submissions

Appendix C

Summary of Findings from Interviews and Written Submissions

The interviews conducted were wide-ranging and comments were diverse. We have summarized below only those comments which were common, to at least, a significant proportion of interviewees. The comments are grouped by the categories of interviewee, e.g., Mental Health Services program staff, facility operators, Continuing Care staff, and B.C. Pricare staff.

A. MHS Program Staff

1. Per diem method of funding:

- Frequent sales of facilities at inflated prices have caused the capital costs to new owners to escalate above the rates currently received from the program.
- The per diem rates favour larger facilities since these facilities enjoy economies of scale.
- Per diem funding does not encourage operators to make their residents better since:
  - Residents made better will eventually be categorized at lower levels of care with the result that per diem funding rates will be decreased.
  - Operators do not want to lose residents since they may not get replacements for some time and any replacement will likely require higher costs of care, at least initially.
- There is a lot of time and effort spent haggling with operators about the category of the residents. Operators are continually trying to get their residents classified upwards in order to get the higher per diem rates.

- Merging the per diem with the Social Services allowance, a user fee which would simplify administration for both MHS and the operators, and is worth investigating.

2. **The revised payment method of funding:**

   - The method gets away from the resident classification debates.
   - Some pressure is taken away from MHS to keep beds full.
   - Contracting allows MHS to enforce standards.
   - Head office in Victoria did not consult with the regions about the method to receive some feedback and to try to get regions acceptance.
   - The method will cost extra money for the funding of smaller facilities because smaller facilities have higher fixed costs per diem than larger facilities.
   - The method is wasteful in that empty beds are paid for in full, whilst the operator will at least be saving the food cost.
   - The method should only have been implemented after negotiations with BC Pricare had been completed.
   - The method will only attract operators if there is extra funding which can be negotiated. Currently, the budgets of the regions do not allow any extra funding.
   - More staff will be needed in the revised program (for reviewing financial information, negotiations, etc.) as the method is very time-consuming. Someone is needed who can analyze the financial information submitted and reconcile this information to the financial statements as there are often inconsistencies.
   - The system would breakdown if more than a couple of operators in each district decided to actively negotiate with MHS because of all the analysis and negotiating time involved.
   - At a minimum the Regional Director should be given the spending authority to sign contracts. It was felt that this would cut down on processing time. Currently the spending authority rests with the Executive Director in Victoria. Responsibility for a region's budget rests, however, with the Regional Director.

- Regions should be given control over their budgets. Currently the Ministry can appropriate any unspent and uncommitted budget monies.

- Regions needs to know what their budget is as close to the start of the fiscal year as possible in order that they can negotiate funding with operators as close as possible to the start of the fiscal year.

- The method allows MHS to look at special rehabilitation programs being proposed by the operators and this is an exciting development.

- The method will allow easier enforcement of staffing levels.

3. **Non-profit organizations:**

   - Per diem funding is significantly higher for non-profit organizations than proprietary facilities.

   - Non-profit organizations are generally old, rundown, and overstaffed administratively.

4. **Levels of funding relative to other government programs:**

   - Social Services and Housing funds the mentally handicapped program at significantly higher per diem rates than MHS.

   - Until fiscal 1991/92, Long Term Care's per diem funding of facilities with less than 15 beds was very close to MHS's per diem funding as were the annual percentage rate increases. Starting in 1991/92 this changed with LTC's % increase being roughly 13% versus MHS' increase of 3.75%. This has really alienated the operators from MHS. MHS has lost credibility with the operators.

5. **Trends being set by the government and MHS:**

   - Section 12 of the Community Care Facility Act is now coming into effect, requiring that facilities have no more than 2 person bedroom occupancy. This puts operators of facilities with 3-4 beds per room in a difficult situation. They do not have the money to build one bed units out of 3-4 bed units. If they do build 1 bed units they will lose some beds because of the new minimum floor space standards for bedrooms. A loss of beds will mean a loss of funding but no decrease in the fixed property costs. This will put some operators, many of them good operators providing a unique and essential service, out of business unless their funding is increased. Implementation of Section 12 is going to cost the Ministry more money if the Ministry wishes to keep the older and larger facilities.

Some facilities may be able to apply for a variance to licencing in the short term, but in the longer term, all will have to comply.

- There is a need to increase the number of beds in the residential program, to accommodate 500 beds to be transferred out of Riverview over the next ten years, and an additional expected growth of approximately 5% per year. MHS is planning on downsizing the larger out of the way facilities by reducing their occupancy, enforcing Section 12, and encouraging the opening of smaller facilities within certain urban areas. MHS wants residents to be rehabilitated such that the individual can go and live on his own under the semi-independent living program.

6. Standards of care:

- Before the Mental Health Services Policy manual was issued in 1987, MHS relied largely on licencing to enforce standards. The manual did not really increase standards, merely documented them. Now that MHS is starting to enforce standards they are relying on cooperation from licensing.

- The only clout for enforcing standards under the per diem basis of funding is to hold back the filling of bed vacancies.

7. Other points:

- For the community residential program to work there must be a partnership between MHS and the operators. Currently, there are some good partnerships but with the enforcement of new standards there must be the increased funding to allow the operators to meet these new standards. The current trend towards enforcing new standards but not compensating operators for the extra costs arising is going to break the partnership.

- Capital replacement and upgrades is a very big issue to long-term operators. Those in the business for several years simply do not have the money to replace and upgrade their capital. Any extra money is spent on wages in an attempt to keep professional staff. The government will not fund private operators for capital because the operator could turn around and sell the assets. One solution suggested was that the government buy the operator's facility and lease it out to the best proposal submitted by bidding operators, thus separating ownership from operation. All the private operators and all MHS officials liked the idea.

- Downsizing of the larger facilities, is a necessity for the clients sake. Most MHS regions had plans for downsizing, and would use section 12 to enforce the downsizing.

B. Facility Operators

1. Nature of operations and care levels:

- There was a need for one-person bedrooms, to enhance privacy and dignity.

- Operators in the Lower Mainland often had specialized their operations for certain types of clients, such as organic brain syndrome clients, short-stay clients, etc. They felt that these special client groups required higher levels of care than what the grey manual specified.

- All operators were aware of the policy manual entitled *"Service Provider Standards and Guidelines"*. Most felt that the minimum staffing standards set out by the manual were not sufficient, for the more difficult IC3s.

- Smaller operators did not like how FTEs were broken down into decimals. They felt that it is impossible to hire a care-worker for 3 FTEs.

- All operators felt that there had been no relative shift between their categories of operating costs in the last 3-5 years.

2. Funding:

- Some non-profit operators said they were negotiating 1990/91 funding based upon a submitted budget, whilst others said they were given no choice but to negotiate funding under the revised payment system.

- All proprietary operators felt that they could not meet the current minimum staffing levels set out by the manual with their current level of funding. If they met these minimum standards then they would have to pay even lower wages. and would lose all their staff. Most of them mentioned how they had recently lost professional staff as a result of not paying competitive wages. Five private operators interviewed disclosed that their annual wage was only around $35,000 per year and that they were registered nurses.

3. **Revised payment system:**

- All operators liked the idea of being funded based upon capacity versus occupancy.

- Most operators felt that MHS negotiators were not really negotiating as they did not have the extra money or willingness to fund them more.

- In terms of staffing, operators found MHS to want to set higher FTE levels but that they could not supply any wage increases and in one case MHS wanted wage reductions as after all the other areas had been negotiated there was not enough money left in the budget to pay the current non-union wage rates.

- Some smaller operators who were negotiating under the revised payment system felt that they would be further ahead in terms of greater FTE funding.

- Operators with a mortgage felt that even though they might be a little ahead in terms of total funding under the revised payment system the fact that they could not allocate this funding to cover their property costs made the method impractical. These operators preferred a method of negotiated global funding.

- All operators felt that the revised payment system did not address the issue of funding transportation. Some felt that the only way they could make a profit under the $3.00 admin per diem would be not to drive the clients anywhere and these operators were unprepared to hurt their clients in this way.

4. **Business relationship:**

- All operators felt that they had a good relationship with their MHS social worker.

- Most operators felt that staff at the local MHS office treated them in a condescending or parental manner.

- Most operators had a good opinion of the MHS director and/or regional director or coordinator.

- Most operators felt they were treated them with suspicion in terms of profit.

- Most operators did not object to having the MHS social worker negotiate funding with them (although they did mention conflict of interest).

- All private operators wished that the MHS negotiators had more autonomy to sign the agreement.

C. Continuing Care Division Executives

- A service provider contract is essential for all operators. They use a simple one-and-a-half page agreement which refers to the service provider manual.

- Individual contract negotiations with each facility would be an impossible administrative task.

- It is correct that Continuing Care rates are higher than MHS as MHS residents are generally mobile and go out to daily programs whilst Continuing Care residents are generally immobile and therefore need all-day supervision.

- Continuing Care do not see downsizing facilities as important as it might be for MHS. The ideal for Continuing Care could be around 20 to 25, and these units can easily be accommodated in separate wings or floors of much larger facilities.

- Non-profit organizations get the same rates as private facilities under Continuing Care, with the exception of the capital element where Non-profit organizations get funded their costs, whilst private facilities get an allowance of $7.50 per resident day.

- The huge gap between rates for larger facilities and under-15 bed facilities is unjustified and presents problems where two similar facilities are near each other, but fall into different classifications. Many of the larger facilities have better physical plant and specialist staff which does partly justify higher rates.

D. B.C. Association of Private Care

- Salaries paid by their members are between 30 and 40% less than Riverview's mid-point rates for the same levels. Owner/managers earn 50% less than union rates for their level of work. Registered nurses rates paid by members are similar to union rates, but rates paid to aides and support staff are 15% to 25% below union rates.

More than 84% of members provide no employment benefits such as medical, dental, pension or insurance plans. The result is high staff turnover, and the risk of unionization.

- Some members are in a serious financial crisis situation and an increasing number will be forced into closing.

- The Negotiated Reimbursement System does not recognize the true cost of providing the required services, and there is no provision for a return on investment.

- Over the last five years the average per diem rate increase has been only 4.1%, and only 1.7% for the IC3 level which 48% of the residents in members' facilities fall into.

- In 1987 MHS introduced staffing requirements which represented a 37% increase for IC2 and a 69% increase for IC3 in costs.

- The rates for Long Term Care facilities are between 11% and 15% higher than for MHS facilities.

- New facilities such as the Katherine Sanford Homes which are being developed in Vancouver, are funded at significantly higher rates than existing facilities.

- There is a significant financial impact on facilities as a result of changing rooms to two-bed occupancy. Most facilities are old and were not purpose built. There has been no funding offered for these increased expectations.

- The multiple roles of social workers in assessment, placement, case management, monitoring and overall funding has the potential for conflict of interest.

- The Negotiated Reimbursement (Revised Payment) System provides inadequate funding for capital of around $7 to $8, whereas members' capital costs are between $11 and $13.

- A legal opinion has been obtained from a larger private facility operator, that the new system of remuneration cannot be unilaterally pushed onto Mental Health facility owners who do not consent to its imposition.

Appendix D

Questionnaire

No. _____

Mental Health Residential Program

Facility Operators Questionnaire

Section 1 Service Definition and Client Profile

In this section, we are asking for basic descriptive information about the services provided in your facility and the clients who use them. The purpose is to understand how differences in service and client characteristics might affect costs and funding requirements. Unless otherwise instructed, please put a check mark (√) beside the answer of your choice.

1.1 What type of license does your facility presently hold?

1) Personal Care License ☐ (1)

2) Intermediate Care License ☐ (2)

3) Specialized Care License ☐ (3)

4) Other (please specify) ☐ _____ (4)

1.2 How many beds does your facility presently maintain for mental health clients? (please enter the number in the space provided)

number of beds _____ (5)

1.3 What was the total occupancy in your facility (total number of resident days) for the fiscal year ending March 31, 1991? (please enter the number in the space provided)

number of resident days in 1990-1991 _____ (6)

1.4 Approximately what proportion of these resident days were in each level-of-care category? (please enter the appropriate percentage in the space provided)

a)	proportion in Personal Care	____%	(7)
b)	proportion in Intermediate Care 1	____%	(8)
c)	proportion in Intermediate Care 2	____%	(9)
d)	proportion in Intermediate Care 3	____%	(10)
e)	proportion in Extended Care	____%	(11)
	Total, all resident days	100%	(12)

1.5 Have these proportions remained relatively the same in 1991?

1) Yes ☐ 2) No ☐ (13)

If no, how have the proportions in each level-of-care category changed? (please enter the appropriate percentage in the space provided)

a)	proportion in Personal Care	____%	(14)
b)	proportion in Intermediate Care 1	____%	(15)
c)	proportion in Intermediate Care 2	____%	(16)
d)	proportion in Intermediate Care 3	____%	(17)
e)	proportion in Extended Care	____%	(18)
	Total, all resident days	100%	(19)

1.6 Do you feel the assessment process through which clients are assigned to these different care levels is a fair one?

1) Yes ☐ 2) No ☐ (20)

Please explain your answer:

_____

_____

Section 2 Local and Facility Factors

In this section, we are seeking an understanding of the physical characteristics of your facility and its location, since these factors may have an impact on your costs. Unless otherwise instructed, please put a check mark (√) beside the answer of your choice.

2.1 How old is your building? (please enter the number in the space provided)

Age of original building ____ (years) [21]

(Note: if there are any new additions to the building, use the age of the original part only)

2.2 a) Does the building presently require any major renovations or building improvements (i.e., new roof, re-wiring, plumbing, etc.)?

1) Yes ❑ 2) No ❑ [22]

If yes, please describe (briefly) the type of renovation or improvement:

_____

_____ [23]

b) Have you applied for any variances under the Community Care Facility Act (Section 12)?

1) Yes ❑ 2) No ❑ [24]

If yes, please describe (briefly) these variances:

_____

_____ [25]

2.3 How far is your facility from the nearest municipal and/or service centre?

1) 0 to 3 kms. ☐
2) 3.1 to 10 kms ☐
3) 10.1 to 20 kms ☐
4) over 20 kms. ☐ (26)

2.4 What is the population of the municipality in which your facility is located? (please enter the number in the space provided)

approximate number of people ____ (27)

2.5 Are there other mental health residential care facilities located in this municipality?

1) Yes ☐ 2) No ☐ (28)

2.6 Please provide the following cost information for your facility in fiscal year ending March 31, 1991. (please enter the dollar number in the space provided)

annual property taxes $_____ (29)

annual hydro charges $_____ (30)

annual heating costs $_____ (31)

annual capital costs $_____ (32)

annual maintenance costs $_____ (33)

2.7 In what years, if any, did your facility take out a first and second mortgage? (please enter the year in the space provided)

year of first mortgage _____ (34)

year of second mortgage _____ (35)

2.8 What was the approximate range of hourly wages received by residential health care workers in the fiscal year 1990-1991? (please enter the wage dollars and position title of the person to whom it relates in the spaces provided)

lowest hourly wage $_____ for the position of _____ [36][37]

highest hourly wage $_____ for the position of _____ [38][39]

2.9 a) What was the total salaries and wages cost of your facility in the fiscal year 1990-1991 (excluding benefits)? (please enter the dollar amount in the space provided)

total salary and wage cost $_____ [40]

b) Does this include salaries and wage costs for owners/managers?

1) Yes ❑ 2) No ❑ [41]

If yes, how many positions and at what wage levels?

number of positions _____ [42]

wage levels (annual) $_____ [43]

$_____ [44]

$_____ [45]

$_____ [46]

$_____ [47]

If no, what would a reasonable salary or wage for owners/managers be annually, and for how many positions?

number of positions _____ (48)

wage levels (annual) $_____ (49)

$_____ (50)

$_____ (51)

$_____ (52)

$_____ (53)

Section 3 Service Delivery and Current Funding

In this section, we are interested in the "mode" of service delivery and your current funding arrangements. Unless otherwise instructed, please put a check mark (√) beside the answer of your choice.

3.1 Is your facility a registered non-profit agency?

1) Yes ☐ 2) No ☐ [54]

3.2 Are the staff in your facility members of a union?

1) Yes ☐ 2) No ☐ [55]

3.3 Are you aware of the Mental Health Services "Negotiated Reimbursement Plan" (which funds on a monthly-advance basis, according to a pre-approved annual budget)?

1) Yes ☐ 2) No ☐ [56]

If yes, have you adopted it?

1) Yes ☐ 2) No ☐ [57]

3.4 Has your facility ever received one-time start-up or capital improvement funds from the Ministry of Health?

1) Yes ☐ 2) No ☐ [58]

3.5 Does your facility presently receive funding at the basic client per diem rate* established by the Mental Health Services Division of the Ministry of Health?

1) Yes	☐	(59)
2) An amount less than the basic per diem rate	☐	(60)
3) An amount greater than the basic per diem rate	☐	(61)

** The per diem rates are currently established at:*

Personal Care	*$31.00*
Intermediate Care 1	*$37.35*
Intermediate Care 2	*$43.40*
Intermediate Care 3	*$54.85*
Extended Care	*$54.85*

3.6 Does your facility receive funding from other sources other than the Health per diem fee, the Social Services user fee, and any payments made by the clients themselves?

1) Yes ☐ 2) No ☐ (62)

If yes, what are these other funding sources?

a)	B.C. Housing Commission	☐	(63)
b)	Non-profit fund raising	☐	(64)
c)	Other provincial government funds	☐	(65)
d)	Federal government funds	☐	(66)
e)	Municipal government funds	☐	(67)
f)	Other private funds	☐	(68)

3.7 Did your facility experience a total funding shortfall in any of the past five years?

1) Yes ☐ 2) No ☐ (69)

If yes, what was the approximate amount of this shortfall?

a) 1986 _____ (70)

b) 1987 _____ (71)

c) 1988 _____ (72)

d) 1989 _____ (73)

e) 1990 _____ (74)

Please explain any substantial shortfall:

_____

_____

_____

_____

_____

_____

3.8 Did your facility experience a total funding surplus in any of the past five years?

1) Yes ☐ 2) No ☐ (75)

If yes, what was the approximate amount of this surplus?

a) 1986 _____ (76)

b) 1987 _____ (77)

c) 1988 _____ (78)

d) 1989 _____ (79)

e) 1990 _____ (80)

Please explain any substantial surplus:

_____

_____

_____

_____

_____

_____

Section 4 · Funding Options

In this section, we would like to explore a number of different funding options with you.

The options are described briefly, and followed by a set of questions specific to each option. Unless otherwise instructed, please put a check mark (√) beside the answer of your choice.

Option A—Basic Per Diem

Description: The Mental Health Services Division of the Ministry of Health presently uses a funding process by which they pay a set daily rate or per diem for each client resident in a residential care facility (see applicable rates on pages 6 and 9 of this questionnaire). The rates are intended to cover the client's share of the costs to operate the facility, their food, and the administration of their "resident care plan". This funding option is presently used by most proprietary residential care facilities.

4a.1 Is your facility funded under this option. *Note: If your answer is no, please move on to question 4a.6.*

1) Yes ❑ 2) No ❑ [81]

4a.2 Does the level of funding under this option adequately cover the costs per client of operating the facility, providing meals, and administering resident care plans?

1) Yes ❑ 2) No ❑ [82]

4a.3 Does the level of funding under this option adequately cover building mortgage/rent and any capital costs incurred?

1) Yes ❑ 2) No ❑ [83]

4a.4 Does the level of funding under this option adequately cover wages and costs?

1) Yes ❑ 2) No ❑ [84]

4a.5 If your answer in 4a.2 and/or 4a.3 was "no", to what extent should each of the per diem levels be changed?

	Basic	Required*	
Personal Care	$31.00	_____	(85)
Intermediate Care 1	$37.35	_____	(86)
Intermediate Care 2	$43.40	_____	(87)
Intermediate Care 3	$54.85	_____	(88)
Extended Care	$54.85	_____	(89)
Other (Please describe) _____		_____	(90)

* *If the basic rate is presently insufficient to cover the costs of providing services at your facility, please show the level of funding required for each per diem component*

4a.6 Apart from the adequacy of the funding level, do you feel the process through which calculated per diem rates are applied is a fair one?

1) Yes ☐ 2) No ☐ (91)

Please explain your answer:

_____

_____

_____

_____

_____

_____

Option B—Budget-Calculated Per Diem

Description: Mental Health Services also use a funding process by which the per diem for each client is calculated from an operating budget submitted each year by a facility. Like the Basic Per Diem Option, the rates are intended to cover the client's share of the costs of operating the facility, their food, and the administration of their "resident care plan". In addition, however, any capital expenditures planned for the year are pro-rated for the anticipated number of clients, and are then calculated into the per diem rates. This funding option presently applies to most non-profit residential care facilities.

4b.1 Is your facility funded under this option? *Note: if your answer is no, please move on to question 4b.5.*

1) Yes ☐ 2) No ☐ (92)

4b.2 Does the level of funding under this option adequately cover the costs per client of operating your facility, providing meal and administering resident care plans?

1) Yes ☐ 2) No ☐ (93)

4b.3 Does the level of funding under this option adequately cover building mortgage/rent and any other capital costs incurred?

1) Yes ☐ 2) No ☐ (94)

4b.4 Does the level of funding under this option adequately cover wages and costs?

1) Yes ☐ 2) No ☐ (95)

4b.5 Apart from the adequacy of the funding level, do you feel the process through which budget-calculated per diem rates are applied is a fair one?

1) Yes ☐ 2) No ☐ (96)

Please explain your answer:

Option C—Negotiated Reimbursement Plan

Description: The Mental Health Services Division has recently introduced a "Negotiated Reimbursement Plan" which, like Option B, is based on the submission of an annual budget from the facility and negotiated with the mental health region. However, unlike Option B, payments are made prospectively on the basis of anticipated operating expenditures each month rather than retrospective payments for the number of clients in the residence each month. This funding option presently applies to a small number of proprietary residential care facilities.

4c.1 Is your facility funded under this option? *Note: if your answer is no, please move on to question 4c.5..*

1) Yes ☐ 2) No ☐ (97)

4c.2 Does the level of funding under this option adequately cover the costs per client of operating your facility, providing meals and administering resident care plans?

1) Yes ☐ 2) No ☐ (98)

4c.3 Does the level of funding under this option adequately cover building mortgage/rent and any other capital costs incurred?

1) Yes ☐ 2) No ☐ (99)

4c.4 Does the level of funding under this option adequately cover wages and costs?

1) Yes ☐ 2) No ☐ (100)

4c.5 Apart from the adequacy of the funding level, do you feel the process through which the Negotiated Reimbursement Plan is applied is a fair one?

1) Yes ☐ 2) No ☐ (101)

Please explain your answer:

_____

_____

_____

_____

_____

_____

_____

Other

a) If you have any thoughts on revising the system of funding (not the funding level), could you please describe these below. We would like to know not only what changes you would like, but also why you are suggesting such changes (use back of page if more space is required).

b) What other problems or issues aside from funding do you regularly encounter that needs to be dealt with by Mental Health Services?

Thank you for your cooperation.

Please return this questionnaire, in the self-addressed envelope provided, to:

Dr. David Zalinger
Peat Marwick Stevenson & Kellogg
5th Floor, 707 Fort Street
Victoria, BC V8W 3G3

Appendix E

Derived Results

Appendix E

Derived Results

Derived Results

Variable Name	Result	Formula
Costday	Operating cost per resident per occupied day	= {Q#2.6i + 2.6ii + 2.6iii + 2.6iv + 2.6v} divided by Q#1.3
Empday	Unoccupied beds/day	= {(Q#1.2 x 365) - Q#1.3} divided by 365